NON-MEDICARE ENROLLEES
RETIRED COVERAGE ENROLLMENT APPLICATION
Coverage for Member without Medicare

State Health Benefits Program - School Employees' Health Benefits Program
New Jersey Division of Pensions and Benefits
P.O. Box 299 • Trenton, NJ 08625-0299

1. APPLICANT INFORMATION

Were you a part-time employee when you retired? ☐ Yes ☐ No

Social Security Number ___-___-____

Last Name _____ Title *(Jr., Sr., etc.)* ____

First Name _____ MI ____

Street Address *(Include Apartment #)* _____

PO Box _____ City _____ State ____

Zip Code + 4 _____-____ Date of Birth *(mm/dd/yy)* ____ Gender *(M/F)* ____

Area Code ___ Home Telephone Number ___-____ Date of Retirement *(mm/dd/yy)* ____

Status (check one) ☐ Single ☐ Married ☐ Civil Union *(see instructions)* ☐ Divorced ☐ Widowed ☐ Domestic Partnership *(see instructions)*

Former Employer _____

2. LEVEL OF MEDICARE COVERAGE

	YES	NO
Do YOU have Medicare Part A? *(Hospital Insurance)*		
Do YOU have Medicare Part B? *(Medical Insurance)*		
Does YOUR SPOUSE/PARTNER have Medicare Part A?		
Does YOUR SPOUSE/PARTNER have Medicare Part B?		
Does your child have Medicare?		

Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits for at least 24 months) must be enrolled under both Medicare Part A (Hospital) and Part B (Medical) in order to continue coverage under this program. If enrolled, a photocopy of the Medicare card must be submitted with this application.

3. TYPE OF ACTIVITY

— Submit this application if you are a **new enrollee** for SHBP or SEHBP Retired Group coverage. Check one box in Section 2; then complete Section 3 to select Medical Coverage. If you are already enrolled and wish to change coverage, add or delete dependents, or cancel coverage, please submit the *Retired Change of Status Application.*

ENROLLMENT ACTION REQUESTED

☐ New Retiree ☐ New Employer

☐ Survivor Enrollment: Decedent's SS#_____

3A. LEVEL OF COVERAGE *(Check one box)*

☐ Single ☐ Family ☐ Parent/Child(ren)
☐ Member & Spouse/Civil Union Partner *(See Instructions)*
☐ Member & Domestic Partner *(See Instructions)*

3B. MEDICAL COVERAGE *(Check one box only).*

HORIZON	AETNA
☐ NJ DIRECT15	☐ Aetna Freedom15
☐ NJ DIRECT10	☐ Aetna Freedom10
☐ NJ DIRECT1525	☐ Aetna Freedom1525
☐ NJ DIRECT2030	☐ Aetna Freedom2030
☐ Horizon HMO	☐ Aetna HMO
☐ Horizon HMO1525	☐ Aetna HMO1525
☐ Horizon HMO2030	☐ Aetna HMO2030

For HMO Plans, enter Primary Care Physician's ID#: _____

DECLINING/WAIVING COVERAGE

☐ **I do not wish to be covered** under any of the medical plans *(See instructions)*

☐ **I wish to waive coverage** under the medical plans for the following reason: *(See instructions)*

☐ I have coverage with another employer

☐ I have coverage with spouse/partner's employer
List Employer:_____

☐ Other *(Give Reason):*_____

*** Medicare eligible dependents will be placed in the corresponding Aetna Medicare Advantage plan.**

4. DEPENDENT INFORMATION — List eligible dependents to include for coverage and attach required proof of dependency documents *(see instructions on reverse).* Attach another sheet of paper for three or more dependents.

	Spouse/Partner Last Name	First Name	MI	Date of Birth *(mm/dd/yy)*	Gender *(M/F)*	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) *(See Instructions)*
	☐							
Children								

FOR DIVISION USE ONLY

Event Reason: ☐
Effective Date: ____
Location No.: ____ ____

5. I certify that all the information supplied on this form is true to the best of my knowledge. I authorize a pension deduction from my pension check, including initial check, last check benefit, withdrawal check, or return of contributions check as required by the State Health Benefits Commission or School Employees' Health Benefits Commission. I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the plans. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself, or my covered dependents on this application, as the assignee may require. **Anyone eligible for Medicare (age 65 or older or in receipt of Social Security Disability benefits) must be enrolled under both Hospital Insurance (Part A) and Medical Insurance (Part B) in order to continue coverage under this program. PROOF OF ENROLLMENT IS REQUIRED.** If I or a covered dependent enroll in Medicare at a later date, I understand that the Health Benefits Bureau must be notified immediately.

Applicant's Signature: _____ Date: _____

☐ Additional Sheet Attached
☐ Medicare Proof Enclosed

COMPLETING THE NON-MEDICARE RETIRED COVERAGE ENROLLMENT APPLICATION

Be sure to review Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, to verify that you are eligible for enrollment into the **State Health Benefits Program** (SHBP) or **School Employees' Health Benefits Program** (SEHBP).

SECTION 1 — APPLICANT INFORMATION

This section pertains to the person enrolling in the retired group. Complete all requested information, filling in one letter or number per block. Provide month, day, and year for Date of Birth and Date of Retirement (for example: April 12, 1933 = 04 12 33). Please indicate if you were a part-time employee.

SECTION 2 — LEVEL OF MEDICARE COVERAGE

Indicate whether you and/or your spouse/partner and/or child are enrolled in Medicare Parts A and B. Be sure to list the effective dates of the Medicare enrollment. Proof of full Medicare enrollment in Parts A and B is required by the Health Benefits Bureau. Please submit a photocopy of the Medicare card or a letter from Social Security confirming the effective dates of full Medicare enrollment. Members receiving a Social Security Disability who become Medicare eligible, must be enrolled in the full Medicare program — Part A and Part B — in order to have coverage in the SHBP or SEHBP. If submitting proof of Medicare enrollment, check the "Medicare Proof Enclosed" box at the bottom right of the application.

SECTION 3 — TYPE OF ACTIVITY AND ENROLLMENT ACTION REQUESTED

Check one box in Section 3. If you have applied for retirement or are a new retiree, check the first box "New Retiree." If you are enrolling as a Surviving Spouse/Partner or Surviving Dependent, check "Survivor Enrollment."

For changes to existing retired group health benefits coverage **DO NOT USE THIS FORM.** To change plans, add or delete dependents, cancel coverage, and make other changes, SHBP or SEHBP members should complete and submit the *Retired Change of Status Application.*

3A. LEVEL OF COVERAGE — Select a level of coverage based upon who you will be covering. When you first enroll at the time of retirement, you may add eligible dependents. Your eligible dependents are your spouse or civil union partner, or an eligible same-sex domestic partner, and your children under age 26 (see definitions below).

3B. MEDICAL COVERAGE — Check only one box indicating either: **1.**) The medical plan into which you want to enroll; or **2.**) That you do not want medical plan coverage (See "Declining or Waiving Coverage" below); or **3.**) That you want to waive medical plan coverage. (See "Declining or Waiving Coverage" below)

When choosing a HMO plan you must list the identification number (ID #) of your Primary Care Physician.

DECLINING OR WAIVING COVERAGE — If you do not want SHBP or SEHBP coverage, check the box indicating that you do not wish to be covered under any of the medical plans.

If you are requesting to waive enrollment for yourself and any of your eligible dependents because of other group health insurance coverage from a public or private employer, check the box indicating that you wish to waive coverage, indicate if the coverage is through your employment or that of your spouse/partner, and the name of the employer. If coverage is waived you may in the future be able to enroll yourself and your eligible dependents in a SHBP or SEHBP medical plan, provided that you request enrollment within 60 days after your other employer group health coverage ends — proof of loss of coverage is required. See Fact Sheet #11, *Enrolling in Health Benefits Coverage When You Retire*, for more information. Police and Firemen's Retirement System (PFRS) members enrolling under Chapter 330, P.L. 1997 should refer to Fact Sheet #47, *Retired Health Benefits Coverage Under Chapter 330*, for more information

NOTE: Medicare eligible retirees cannot enroll in High Deductible Health Plans (HDHP) or Aetna 2030.

SECTION 4 — DEPENDENT INFORMATION

This section is used for members selecting Member & Spouse/Partner, Family, or Parent & Child(ren) coverage. Please list your spouse/partner's name, gender, date of birth, Social Security number, and if enrolling in a HMO plan the spouse/partner's Primary Care Physician Identification Number. Please also list the name, gender, date of birth, Social Security number, and if enrolling in a HMO plan the Primary Care Physician Identification Number for any children you are enrolling. If you are listing more than two children, please provide the required information for your other children on an additional sheet of paper, attach the sheet to the application, and check the box at the bottom right of the application.

SPOUSE: This is a person to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the covered retiree's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the covered retiree's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the covered retiree's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the retiree as a parent is required for enrollment. If you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required.

Note: Dependents may be added later, using the *Retired Change of Status Application,* either within 60 days of the date of event - i.e., marriage, civil union, birth of a child - with an effective date of the date of the event; or added timely with a 60-day waiting period.

SECTION 5 — CERTIFICATION AND SIGNATURE

The member must read the certification and sign and date the application. If additional sheets are submitted with the application, check the box indicating such.

Misrepresentation: Any person who provides false or misleading information is subject to criminal and civil penalties.

Return this application and all supporting documentation to:

NJ DIVISION OF PENSIONS AND BENEFITS
HEALTH BENEFITS BUREAU
P.O. BOX 299
TRENTON, NJ 08625-0299

HB-0840-0913

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex or same sex to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, *regardless* of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

* ***Note:*** *For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***